PEDIATRIC NATUROPATHIC INTAKE FORM

Child's Name: ________________________________ Sex: M F Date of Birth: _________
Address____
City ______________________________State ________________ Postal Code ___________
Phone (Home) _______________ (Work) ____________________(Cell) ________________
Okay to leave a message? Y N Which number? ___________________
Parent/Guardian name(s): ____
Siblings (names & ages) ____

How was this child referred to our office? ____

Your Child's Other Health Care Practitioners
Name: _______________________________ Phone: _________ Fax: ________________
Name: _______________________________ Phone: _________ Fax: ________________

What is your child's chief health concern(s)?
1. ____
2. ____

Have the above condition(s) been diagnosed by a health practitioner? Y N
If Yes, when and by whom? ____

Does your child receive well-child exams? Yes No
If Yes, from whom? ____

How would you describe your child's current overall state of health?
Excellent Good Fair Poor

CHILD'S HEALTH HISTORY (answer only those questions that are appropriate for the child's age)

Allergies: ____
Sensitivities (environmental/food): ____
Hospitalizations & Surgeries (reasons and dates): _________________________________
____

At what age did your child begin: Teething _____ Crawling _____ Sitting _______
Walking ______ Talking _____ Toilet training _______

Were there any problems or concerns at any of these developmental stages? ______________
____

Please indicate with an [X] whether your child has experienced any of the following conditions:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Colds		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Coordination problem		Whooping cough	
Learning difficulties		Behavior problems		Eating problems		Other	

If other, please describe: ____

Is there any condition from which you feel your child has **never been well since? ____________**

IMMUNIZATION HISTORY

Please check with an [X] the vaccinations your child has received. If you don't know if you've had one, place a question mark beside it.

	Date		Date
Diphtheria, Pertussis, Tetanus		Measles, Mumps, Rubella	
Polio		Varicella	
Haemophilus influenza B		Hepatitis B	
Influenza		Pneumococcal	
Meningococcal		Other	

Any adverse reactions following vaccination? (Check all that applies)

Fever		Excessive crying		Pain/Swelling		Behavior Changes	
Joint pain		Limping		Mood changes		Rash	
Loss of appetite		Vomiting		Insomnia		Other	

If other, please describe ____

MEDICATION HISTORY

Please list all over-the-counter and prescription medications & supplements:

Medication/Supplement	Dose	Reason for Use

FAMILY HISTORY

Indicate check with an [X] if anyone in your family has or has had any of the following conditions.

	Father	Mother	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if living)								
Health (G=good; P=poor)								
Anemia								
Asthma								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Age (at death)								

If other, please describe: ____

Was this child adopted? Yes N

PRENATAL HISTORY

What age was mother at child's conception?________Father's age at conception?_______
Parent's health at conception (E = Excellent, G = Good, P = Poor)
Mother: ______ Father: ________
Was your child conceived naturally? Yes No
Was there any difficulty conceiving this child? Yes No
Any fertility interventions? Yes No If yes, explain: __________________________________
____
List any illnesses, medications or exposures to toxins during pregnancy: ______________________
____

Medications (over the counter & prescriptions), supplements and herbs taken during the pregnancy:
____

Please indicate with an [X] any health conditions mother experienced during the pregnancy. Check all that applies.

Diabetes		Edema (swelling)		Emotional trauma		Fainting	
Rubella		Infection(s)		High blood pressure		Thyroid Problems	
Nausea/Vomiting		Physical trauma		Bleeding		Anxiety/Fear	
Depression		Other					

If other, please describe: ____

How was the mother's physical and emotional health during postpartum/recovery? _______________
____

LABOR & DELIVERY

Duration of pregnancy (weeks): ____________ Duration of labor (hours): _______________

Location of labor & delivery: Home Birthing Center Hospital

Please indicate with an [X] which intervention were used during birth. Check all that applies.

Induced labor		Forceps		Vacuum extraction		Epidural/Anesthesia	
Episiotomy		Oxytocin/Pitocin		Pain Medication		Cesarean section	
Other:							

NEONATAL HISTORY

Birth weight: ____________ Birth length: ______________

Any difficulties or complications soon after birth? Check all that applies.

Jaundice		Poor feeding	
Respiratory distress		Anemia	
Convulsion		Infection(s)	
Birth defects		Colic	
Other			

If other, please describe: ____

NUTRITIONAL HISTORY

Was your child breastfed? Yes No If yes for how many months? ______

Any difficulties with breastfeeding? Yes No If yes, what were the difficulties?

____

What type & brand of infant formula, if any, was used? ______________________________________

Age solid foods were introduced: _________________________________

How would you describe your child's eating habits? ____

Food Aversions? Yes No Food cravings? Yes No

Any dietary restrictions? Yes No If yes, please explain: ____________________________________

Number of bowel movement daily? _______ Any difficulties? Yes No

Please list the solid foods introduced prior to 12 months of age, and any reactions noted:

FOOD	AGE OF INTRODUCTION	RESPONSE/REACTION

Please outline your child's typical daily food intake:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Water intake (ounces): _______ What source (tap, filtered, distilled, spring)? ________________

Other fluids: ____

SLEEP HISTORY

Does your child sleep through the night? Yes No
Number of hours of sleep nightly? ______________________
Naps? Yes No
Bad dreams or nightmares? Yes No

Have you observed any of the following during your child's sleep? Check all that applies.

Sleepwalking		Shouting		Teeth grinding	
Talking		Moaning		Perspiration	
Laughing		Twitching		Other	

If other, please describe: ____

SOCIAL/PSYCHOLOGICAL HISTORY

How would you describe your child's temperament? __________________________________
How does your child interact with others? ____
Please indicate any emotional traumas your child has experienced: _______________________
____
How does your child handle stress? ____
How does your child have any unusual habits? _______________________________________
What are your child's favorite activities? ____
How often does your child exercise? ____
How many hours weekly does your child:
Play on the computer or video games: __________Watch TV: ___________ Read books__________
Any behavioral or learning problems? Yes No
How is your child's performance in daycare/school? __________________________________

Is there anything else you would like to add that may be important regarding your child's health?
____

Thank you for taking the time to complete this detailed questionnaire. This information is kept confidential and will be a valuable resource as we work together to optimizing your child's health.